| TDDDCTAG | | | | NORTH CAROLINA | | Ph. 10 | AGE: 1 | 1 |
|-----------------------|--------------------------------|--------------|-----------|---|---------|---------|--|--------|
| IPDR6702 RUN DATE: | : 09/17/2006 | | IP | NORTH CAROLINA RS CHECKWRITE SUMMARY REPORT | | PF | AGE: 1 | |
| | | | | CHECKWRITE DATE: 09/19/2006 | | | | |
| | | | | FINANCIAL PAYER: NCDMH | | | | |
| | | | | | | | TOTAL | TOTAL |
| PROVIDER | | HIGH DENIAL | NUMBER OF | | TNC | TOTAL | CLAIMS | CLAIMS |
| NUMBER | PROVIDER NAME | EOBS | DENIALS | DESCRIPTION | DENIALS | DENIALS | FINALIZED | PAID |
| 3404901 | SMOKY MOUNTAINM | 11 | 507 | CLIENT NOT ELIGIBLE ON SERVICE | | | | |
| | H/DD/SAS | | | DATE | | | | |
| | | | | | | | | |
| | | n | n | | | 507 | 507 | |
| | | | | | 0 | 307 | 307 | 0 |
| | | | | | | | | |
| 3404904 | WESTERN HIGHLAN | 21 | 1094 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| | DS LME | | | | | | | |
| | | | | | | | | |
| | | 3411 | 153 | PROVIDER TYPE AND SPECIALTY 07 | 0 | 1678 | 30789 | 29111 |
| | | | | 4/113 CANNOT BILL ENHANCED BENEFIT SERVICES ON OR AFTER D | | | | |
| | - | | | BENEFIT CENTRED ON ON INTERVE | | | | |
| | | 191 | 139 | CLIENT ID NUMBER DOES NOT MATC | | | | |
| | | | | H PATIENT NAME | | | | |
| | + | + | | | - | - | | |
| 3404910 | PATHWAYS | 11 | 281 | CLIENT NOT ELIGIBLE ON SERVICE | | | <u> </u> | |
| | | | | DATE | | | | |
| | | | | | | | | |
| | + | 21 | 62 | DUPLICATE OF CLAIM-SYSTEM | 9 | 379 | 953 | 574 |
| | + | | | | 9 | 3/9 | 953 | 5/4 |
| | | | | | | | | |
| | | 143 | 13 | CLIENT ID NUMBER NOT ON STATE | | | | |
| | + | 143 | 13 | ELIGIBILITY FILE | | | + | |
| | | | | | | | | |
| | | | | | | | | |
| 3404912 | CATAWBA COUNTYM ENTAL HEALT | 8935 | 12 | ASTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS. | | | | |
| | ENIAL REALI | | | | | | | |
| | | | | | | | | |
| | | 191 | 3 | CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME | 13 | 16 | 1060 | 1044 |
| | + | | | R FAILENI NAME | | | | |
| | | | | | | | | |
| | | 8931 | 1 | AMTNC INELIGIBLE TO RECEIVE SE | | | | |
| | | | | RVICES IN IPRS. | | | | |
| | - | | | | | | | |
| 3404913 | MECKLENBURG COM | 11 | 5044 | CLIENT NOT ELIGIBLE ON SERVICE | | | | |
| | ENTAL HEALT | | | DATE | | | | |
| | | | | | | | | |
| | | 8599 | 766 | DETAIL NOT COVERED BY COMBINAT | 116 | 6420 | 10519 | 4099 |
| | | | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | | | | BENEFIT PACKAGE. | | | | |
| | + | 143 | 392 | CLIENT ID NUMBER NOT ON STATE | | | | |
| | <u> </u> | | | ELIGIBILITY FILE | | | | L |
| | | 1 | | | | | 1 | |
| 3404916 | CROSSBOADS BEUN | 79 | 25 | THIS SERVICE IS NOT PAYABLE TO | | | - | |
| | CROSSROADS BEHA VIORAL HEAL | - | | YOUR SUBMITTED BILLING | | | | |
| | | | | PROVIDER TYPE AND SPECIALTY IN | | | | |
| | + | 3412 | 10 | PROVIDER TYPE AND SPECIALTY 07 | | | 1 | |
| | + | 2414 | 10 | PROVIDER TYPE AND SPECIALTY 07 4/113 CANNOT BILL ENHANCED | 0 | 47 | 945 | 898 |
| | | | | BENEFIT SERVICES ON OR AFTER D | | | | L |
| | | 2412 | _ | PROGRAMME AND ADDRESS OF | | | | |
| | + | 3411 | ٥ | PROVIDER TYPE AND SPECIALTY 07 4/113 CANNOT BILL ENHANCED | - | - | | |
| | + | | | BENEFIT SERVICES ON OR AFTER D | | | | |
| | | | | | | | | |
| 3404917 | CENTERPOINT HUM | 11 | 1135 | CLIENT NOT ELIGIBLE ON SERVICE DATE | | | | |
| | AN SERVICES | + | | | | | | |
| | | 1 | 1 | | | | <u> </u> | |
| | | | | | | 1 | 1 | |
| | | 8599 | 1010 | DETAIL NOT COVERED BY COMBINAT | 76 | 2443 | 6984 | 4541 |
| | | 8599 | 1010 | ION OF RECIPIENT, PROVIDER AND | 76 | 2443 | 6984 | 4541 |
| | | 8599 | 1010 | | 76 | 2443 | 6984 | 4541 |
| | | 8599 8536 | 1010 | ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. ATTENDING PROVIDER TYPE AND SP | 76 | 2443 | 6984 | 4541 |
| | | | | ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | 76 | 2443 | 6984 | 4541 |

| PROVIDER | | HIGH DENIAL | NUMBER OF | | muo | momay | TOTAL | TOTAL |
|----------|-----------------|-------------|-----------|--|----------------|---------|---------------------|----------------|
| NUMBER | PROVIDER NAME | EOBS | DENIALS | DESCRIPTION | TNC DENIALS | TOTAL | CLAIMS FINALIZED | CLAIMS PAID |
| | PROVIDER NAME | | | | DENIALS | DENIALS | FINALIZED | PAID |
| 3404919 | GUILFORD CO MEN | 8599 | 135 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | TAL HEALTHC | | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | | | | BENEFIT PACKAGE. | | | | |
| | | 3411 | 63 | PROVIDER TYPE AND SPECIALTY 07 | 48 | 432 | 10707 | 10275 |
| | | | | 4/113 CANNOT BILL ENHANCED | 40 | 432 | 10707 | 10273 |
| | | | | BENEFIT SERVICES ON OR AFTER D | | | | |
| | | | | | | | | |
| | | 8536 | 61 | ATTENDING PROVIDER TYPE AND SP ECIALTY COMBINATION IS NOT | | | | |
| | | | | VALID FOR SUBMITTED BILLING PR | | | | |
| | | | | | | | | |
| 3404920 | ALAMANCE CASWEL | 8534 | 628 | SERVICE FACILITY LOCATION IS N | | | | |
| | L AREA MH D | | | OT A VALID IPRS ATTENDING | | | | |
| | | | | PROVIDER. PLEASE VERIFY THE F | | | | |
| | | 8599 | 290 | DETAIL NOT COVERED BY COMBINAT | 77 | 1428 | 4263 | 2835 |
| | | | | ION OF RECIPIENT, PROVIDER AND | ,,, | 1420 | 4203 | 2033 |
| | | | | BENEFIT PACKAGE. | | | | |
| | | | | | | | | |
| | | 21 | 116 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| | | | 1 | | | | | |
| | | | | | | | | |
| 3404921 | ORANGE PERSON C | 11 | 284 | CLIENT NOT ELIGIBLE ON SERVICE | | | | |
| | HATHAM AREA | | | DATE | | | | |
| | | | | | | | | |
| | | 27 | 266 | DIAGNOSIS CODE MISSING OR INVA | 0.1 | 0.57 | 2615 | 0740 |
| | 1 | | | LID. VERIFY AND ENTER THE | 21 | 867 | 3615 | 2748 |
| | 1 | | | CORRECT DIAGNOSIS CODE AND SUB | | | | |
| | | | | | | | | |
| | | 120 | 39 | CLIENT ID NUMBER MISSING OR IN | | | | |
| | | | | VALID. ENTER CID AND SUBMIT AS A NEW CLAIM | | | | |
| | | | | AS A NEW CLAIM | | | | |
| 3404922 | THE DURHAM CENT | 3411 | 2298 | PROVIDER TYPE AND SPECIALTY 07 | | | | |
| | ER | | | 4/113 CANNOT BILL ENHANCED | | | | |
| | | | | BENEFIT SERVICES ON OR AFTER D | | | | |
| | | | | | | | | |
| | | 3412 | 2026 | PROVIDER TYPE AND SPECIALTY 07 4/113 CANNOT BILL ENHANCED | 25 | 6443 | 14352 | 7909 |
| | | | | BENEFIT SERVICES ON OR AFTER D | | | | |
| | | | | | | | | |
| | | 8329 | 551 | CLAIM DENIED ATTENDING PROVIDE | | | | |
| | | | | R CANNOT BE THE SAME AS | | | | |
| | | | | THE LMA | | | | |
| 3404923 | FIVE COUNTY MH | 11 | 500 | CLIENT NOT ELIGIBLE ON SERVICE | | | | |
| | FIVE COUNTY MIT | | | DATE | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | 21 | 477 | DUPLICATE OF CLAIM-SYSTEM | 0 | 2093 | 7293 | 5200 |
| | | | | | | | | |
| | | | | | | | | |
| | | 8599 | 370 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | | | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | | | | BENEFIT PACKAGE. | | | | |
| 3404925 | CANDUTTEC CONTR | 8599 | 264 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | R FOR MH/DD | | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | | | | BENEFIT PACKAGE. | | | | |
| - | | | | | | | - | |
| | | 8536 | 98 | ATTENDING PROVIDER TYPE AND SP ECIALTY COMBINATION IS NOT | 4 | 511 | 7749 | 7238 |
| | | | 1 | ECIALTY COMBINATION IS NOT VALID FOR SUBMITTED BILLING PR | | | | |
| | | | <u> </u> | | | | | |
| | | 11 | 79 | CLIENT NOT ELIGIBLE ON SERVICE | | | | |
| | | | | DATE | | | | |
| | | | | | | | | |
| 3404926 | SOUTHEASTERN RE | 21 | 555 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| | G MENTAL HL | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | 3411 | 205 | PROVIDER TYPE AND SPECIALTY 07 | 15 | 1169 | 2376 | 1207 |
| | | | 1 | 4/113 CANNOT BILL ENHANCED BENEFIT SERVICES ON OR AFTER D | | | | |
| | | | | TO DENVIOLE ON ON RETER D | | | | |
| | 1 | 8599 | 146 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | | | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | 1 | | | BENEFIT PACKAGE. | | | | |
| | | | | | | | | |

| PROVIDER NUMBER | | | | | | | TOTAL | moma r |
|--------------------|---|--|--|--|---------|---------|-----------|--------|
| | | HIGH DENIAL | NUMBER OF | | TNC | TOTAL | CLAIMS | TOTAL |
| | DROUT DED NAME | EOBS | DENIALS | DESCRIPTION | | | FINALIZED | |
| | PROVIDER NAME | 2020 | DENTITED | DECORT TON | DENIALS | DENIALS | FINALIZED | PAID |
| 3404927 | OUR PROPERTY AND GO IN | 11 | 126 | CLIENT NOT ELIGIBLE ON SERVICE | | | | |
| 3101327 | CUMBERLAND CO M HC | | 120 | DATE | | | | |
| | HC | | | DILL | | | | |
| | | | | | | | | |
| | | 8622 | 59 | 60 RESIDENTIAL LEVEL II TREATM | _ | | | |
| | | 0022 | 33 | ENT RECEIVED, PA IS REQUIRED | 0 | 366 | 1732 | 1366 |
| | | | | FOR ADDITIONAL SERVICE. | | | | |
| | | | | FOR ADDITIONAL SERVICE. | | | | |
| | | 5404 | | ORIGINAL DUDY YOURS ONLY ARREST OR | | | | |
| | | 5404 | 55 | SEVERE DUPLICATE: SAME ATTO PR | | | | |
| | | | | OV/PCODE/TOS/DOS/MOD | | | | |
| | | | | | | | | |
| | | | | | | | | |
| 3404930 | JOHNSTON COUNTY | 0 | 0 | *** NO DATA TO REPORT *** | | | | |
| | MNTL HLTHC | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | 0 | 0 | | 0 | 0 | 0 | 0 |
| | | | | | | | | |
| | | | | | | | | |
| 3404931 | WAKE CO HUM SVC | 191 | 301 | CLIENT ID NUMBER DOES NOT MATC | | | | |
| | BILLING OF | | | H PATIENT NAME | | | | |
| | | | | | | | | |
| | 1 | 1 | 1 | | | | | |
| | | 8536 | 151 | ATTENDING PROVIDER TYPE AND SP | 23 | 699 | 4693 | 3994 |
| | + | | | ECIALTY COMBINATION IS NOT | 23 | 099 | 1093 | 3934 |
| | + | 1 | 1 | VALID FOR SUBMITTED BILLING PR | | | | |
| | + | 1 | + | | | | | - |
| | | 21 | 79 | DUPLICATE OF CLAIM-SYSTEM | | | | - |
| | 1 | ** | | DOLLICATE OF CHAIR-SISTEM | | | | - |
| | | | | | | | | |
| | | | | | | | | |
| | | | L | | | | | |
| 3404933 | SOUTHEASTERN CT | 11 | 73 | CLIENT NOT ELIGIBLE ON SERVICE | | | | |
| | R FOR MH/DD | | | DATE | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | 120 | 37 | CLIENT ID NUMBER MISSING OR IN | 0 | 211 | 1406 | 1195 |
| | | | | VALID. ENTER CID AND SUBMIT | | | | |
| | | | | AS A NEW CLAIM | | | | |
| | | | | | | | | |
| | | 8599 | 35 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | | | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | | | | BENEFIT PACKAGE. | | | | |
| | | | | DINDL'I INCHIOL. | | | | |
| 3404934 | | 3411 | 91 | PROVIDER TYPE AND SPECIALTY 07 | | | | |
| 3404934 | ONSLOW CARTERET | 3411 | 91 | | | | | |
| | BEHAV HEAL | | | 4/113 CANNOT BILL ENHANCED | | | | |
| | | | | BENEFIT SERVICES ON OR AFTER D | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | 11 | 79 | CLIENT NOT ELIGIBLE ON SERVICE | 0 | 306 | 825 | 519 |
| | | 11 | 79 | CLIENT NOT ELIGIBLE ON SERVICE DATE | 0 | 306 | 825 | 519 |
| | | 11 | 79 | | 0 | 306 | 825 | 519 |
| | | 11 | 79 | | 0 | 306 | 825 | 519 |
| | | 11 8535 | 79 | | 0 | 306 | 825 | 519 |
| | | | | DATE | 0 | 306 | 825 | 519 |
| | | | | DATE SERVICE FACILITY LOCATION WAS | 0 | 306 | 825 | 519 |
| | | | | DATE SERVICE FACILITY LOCATION WAS NOT INCLUDED IN YOUR 837. | 0 | 306 | 825 | 519 |
| 3404935 | MEANE OF WEIGHT | | | DATE SERVICE FACILITY LOCATION WAS NOT INCLUDED IN YOUR 837. PLEASE RESUBMIT YOUR CLAIM WIT | 0 | 306 | 825 | 519 |
| 3404935 | MAYNE CO MENTAL | 8535 | | DATE SERVICE FACILITY LOCATION WAS NOT INCLUDED IN YOUR 837. | 0 | 306 | 825 | 519 |
| 3404935 | MAYNE CO MENTAL HEALTH CTR | 8535 | | DATE SERVICE FACILITY LOCATION WAS NOT INCLUDED IN YOUR 837. PLEASE RESUBMIT YOUR CLAIM WIT | 0 | 306 | 825 | 519 |
| 3404935 | | 8535 | | DATE SERVICE FACILITY LOCATION WAS NOT INCLUDED IN YOUR 837. PLEASE RESUBMIT YOUR CLAIM WIT | 0 | 306 | 825 | 519 |
| 3404935 | | 8535 | | DATE SERVICE FACILITY LOCATION WAS NOT INCLUDED IN YOUR 837. PLEASE RESUBMIT YOUR CLAIM WIT | | | | |
| 3404935 | | 8535 | | DATE SERVICE FACILITY LOCATION WAS NOT INCLUDED IN YOUR 837. PLEASE RESUBMIT YOUR CLAIM WIT | 0 | 306 | | |
| 3404935 | | 8535 | | DATE SERVICE FACILITY LOCATION WAS NOT INCLUDED IN YOUR 837. PLEASE RESUBMIT YOUR CLAIM WIT | | | | |
| | HEALTH CTR | 8535 0 | | DATE SERVICE FACILITY LOCATION WAS NOT INCLUDED IN YOUR 837. PLEASE RESUBMIT YOUR CLAIM WIT *** NO DATA TO REPORT *** | | | | |
| 3404935 | HEALTH CTR WILSON-GREENE M | 8535 | | DATE SERVICE FACILITY LOCATION WAS NOT INCLUDED IN YOUR 837. PLEASE RESUBMIT YOUR CLAIM WIT *** NO DATA TO REPORT *** DETAIL NOT COVERED BY COMBINAT | | | | |
| | HEALTH CTR | 8535 0 | | DATE SERVICE FACILITY LOCATION WAS NOT INCLIDED IN YOUR 837. PLEASE RESUBMIT YOUR CLAIM WIT *** NO DATA TO REPORT *** DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND | | | | |
| | HEALTH CTR WILSON-GREENE M | 8535 0 | | DATE SERVICE FACILITY LOCATION WAS NOT INCLUDED IN YOUR 837. PLEASE RESUBMIT YOUR CLAIM WIT *** NO DATA TO REPORT *** DETAIL NOT COVERED BY COMBINAT | | | | |
| | HEALTH CTR WILSON-GREENE M | 8535 0 0 0 8599 | | DATE SERVICE FACILITY LOCATION WAS NOT INCLUDED IN YOUR 837. PLEASE RESUBMIT YOUR CLAIM WIT *** NO DATA TO REPORT *** DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | 0 | 0 |
| | HEALTH CTR WILSON-GREENE M | 8535 0 | | DATE SERVICE FACILITY LOCATION WAS NOT INCLUDED IN YOUR 837. PLEASE RESUBMIT YOUR CLAIM WIT *** NO DATA TO REPORT *** DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. AMTNC INELIGIBLE TO RECEIVE SE | | | | |
| | HEALTH CTR WILSON-GREENE M | 8535 0 0 0 8599 | | DATE SERVICE FACILITY LOCATION WAS NOT INCLUDED IN YOUR 837. PLEASE RESUBMIT YOUR CLAIM WIT *** NO DATA TO REPORT *** DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | 0 | 0 | 0 |
| | HEALTH CTR WILSON-GREENE M | 8535 0 0 0 8599 | | DATE SERVICE FACILITY LOCATION WAS NOT INCLUDED IN YOUR 837. PLEASE RESUBMIT YOUR CLAIM WIT *** NO DATA TO REPORT *** DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. AMTNC INELIGIBLE TO RECEIVE SE | | 0 | 0 | 0 |
| | HEALTH CTR WILSON-GREENE M | 8535 0 0 0 8599 | | DATE SERVICE FACILITY LOCATION WAS NOT INCLUDED IN YOUR 837. PLEASE RESUBMIT YOUR CLAIM WIT *** NO DATA TO REPORT *** DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. AMTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS. | | 0 | 0 | 0 |
| | HEALTH CTR WILSON-GREENE M | 8535 0 0 0 8599 | | DATE SERVICE FACILITY LOCATION WAS NOT INCLUDED IN YOUR 837. PLEASE RESUBMIT YOUR CLAIM WIT *** NO DATA TO REPORT *** DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. AMTNC INELIGIBLE TO RECEIVE SE | | 0 | 0 | 0 |
| | HEALTH CTR WILSON-GREENE M | 8535 0 0 0 8599 | | DATE SERVICE FACILITY LOCATION WAS NOT INCLUDED IN YOUR 837. PLEASE RESUBMIT YOUR CLAIM WIT *** NO DATA TO REPORT *** DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. AMTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS. | | 0 | 0 | 0 |
| | HEALTH CTR WILSON-GREENE M | 8535 0 0 0 8599 | | DATE SERVICE FACILITY LOCATION WAS NOT INCLUDED IN YOUR 837. PLEASE RESUBMIT YOUR CLAIM WIT *** NO DATA TO REPORT *** DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. AMTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS. | | 0 | 0 | 0 |
| | HEALTH CTR WILSON-GREENE M | 8535 0 0 0 8599 | | DATE SERVICE FACILITY LOCATION WAS NOT INCLUDED IN YOUR 837. PLEASE RESUBMIT YOUR CLAIM WIT *** NO DATA TO REPORT *** DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. AMTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS. | | 0 | 0 | 0 |
| 33404936 | HEALTH CTR MILSON-GREENE M ENTAL HEALT | 8535 0 0 0 8599 | | DATE SERVICE FACILITY LOCATION WAS NOT INCLUDED IN YOUR 837. PLEASE RESUBMIT YOUR CLAIM WIT *** NO DATA TO REPORT *** DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. AMTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS. | | 0 | 0 | 0 |
| 33404936 | HEALTH CTR WILSON-GREENE M ENTAL HEALT EDGECOMBE NASH | 8535 0 0 0 8599 8931 | 73 0 0 0 7 7 1 1 1 1 1 1 1 | DATE SERVICE FACILITY LOCATION MAS NOT INCLUDED IN YOUR 837. PLEASE RESUBMIT YOUR CLAIM WIT *** NO DATA TO REPORT *** DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. AMTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS. DUPLICATE OF CLAIM-SYSTEM | | 0 | 0 | 0 |
| 33404936 | HEALTH CTR MILSON-GREENE M ENTAL HEALT | 8535 0 0 8599 8931 | 73 0 0 0 7 7 1 1 1 1 1 1 1 | DATE SERVICE FACILITY LOCATION MAS NOT INCLUDED IN YOUR 837. PLEASE RESUBMIT YOUR CLAIM WIT *** NO DATA TO REPORT *** DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. AMTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS. DUPLICATE OF CLAIM-SYSTEM | | 0 | 0 | 0 |
| 3404936 | HEALTH CTR WILSON-GREENE M ENTAL HEALT EDGECOMBE NASH | 8535 0 0 8599 8931 | 73 0 0 0 7 7 1 1 1 1 1 1 | DATE SERVICE FACILITY LOCATION MAS NOT INCLUDED IN YOUR 837. PLEASE RESUBMIT YOUR CLAIM WIT *** NO DATA TO REPORT *** DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. AMTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS. DUPLICATE OF CLAIM-SYSTEM | | 0 | 0 | 0 |
| 33404936 | HEALTH CTR WILSON-GREENE M ENTAL HEALT EDGECOMBE NASH | 8535 0 0 8599 8931 21 | 73 0 0 0 7 7 1 1 1 1 1 1 | DATE SERVICE FACILITY LOCATION WAS NOT INCLUDED IN YOUR 837. PLEASE RESUBMIT YOUR CLAIM WIT *** NO DATA TO REPORT *** DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. AMTHO INELIGIBLE TO RECEIVE SE RVICES IN IPRS. DUPLICATE OF CLAIM-SYSTEM DUPLICATE OF CLAIM-SYSTEM | 1 | 9 | 1036 | 1027 |
| 33404936 | HEALTH CTR WILSON-GREENE M ENTAL HEALT EDGECOMBE NASH | 8535 0 0 8599 8931 | 73 0 0 0 7 7 1 1 1 1 1 1 | DATE SERVICE FACILITY LOCATION WAS NOT INCLUDED IN YOUR 837. PLEASE RESUBMIT YOUR CLAIM WIT *** NO DATA TO REPORT *** DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. AMTINC INELIGIBLE TO RECEIVE SE RVICES IN IPRS. DUPLICATE OF CLAIM-SYSTEM DUPLICATE OF CLAIM-SYSTEM THIS SERVICE IS NOT PAYABLE TO | | 0 | 0 | 1027 |
| 3404936 | HEALTH CTR WILSON-GREENE M ENTAL HEALT EDGECOMBE NASH | 8535 0 0 8599 8931 21 | 73 0 0 0 7 7 1 1 1 1 1 1 | DATE SERVICE FACILITY LOCATION WAS NOT INCLUDED IN YOUR 837. PLEASE RESUBMIT YOUR CLAIM WIT *** NO DATA TO REPORT *** DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT FACKAGE. AMTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS. DUPLICATE OF CLAIM-SYSTEM THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING | 0 | 9 | 1036 | 1027 |
| 3404936 | HEALTH CTR WILSON-GREENE M ENTAL HEALT EDGECOMBE NASH | 8535 0 0 8599 8931 21 | 73 0 0 0 7 7 1 1 1 1 1 1 | DATE SERVICE FACILITY LOCATION WAS NOT INCLUDED IN YOUR 837. PLEASE RESUBMIT YOUR CLAIM WIT *** NO DATA TO REPORT *** DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. AMTINC INELIGIBLE TO RECEIVE SE RVICES IN IPRS. DUPLICATE OF CLAIM-SYSTEM DUPLICATE OF CLAIM-SYSTEM THIS SERVICE IS NOT PAYABLE TO | 0 | 9 | 1036 | 1027 |
| 3404936 | HEALTH CTR WILSON-GREENE M ENTAL HEALT EDGECOMBE NASH | 8535 0 0 8599 8931 21 21 | 73 0 0 0 7 7 1 1 1 1 1 1 | DATE SERVICE FACILITY LOCATION WAS NOT INCLUDED IN YOUR 837. PLEASE RESUBMIT YOUR CLAIM WIT *** NO DATA TO REPORT *** DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. AMTNC INELIGIBLE TO RECEIVE SE RUICES IN IPPS. DUPLICATE OF CLAIM-SYSTEM DUPLICATE OF CLAIM-SYSTEM THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN | 0 | 9 | 1036 | 1027 |
| | HEALTH CTR WILSON-GREENE M ENTAL HEALT EDGECOMBE NASH | 8535 0 0 8599 8931 21 | 73 0 0 0 7 7 1 1 1 1 1 1 | DATE SERVICE FACILITY LOCATION WAS NOT INCLUDED IN YOUR 837. PLEASE RESUBMIT YOUR CLAIM WIT *** NO DATA TO REPORT *** DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. AMTHO INELIGIBLE TO RECEIVE SE RVICES IN IPRS. DUPLICATE OF CLAIM-SYSTEM THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN DETAIL NOT COVERED BY COMBINAT | 0 | 9 | 1036 | 1027 |
| 3404936 | HEALTH CTR WILSON-GREENE M ENTAL HEALT EDGECOMBE NASH | 8535 0 0 8599 8931 21 21 | 73 0 0 0 7 7 1 1 1 1 1 1 | DATE SERVICE FACILITY LOCATION WAS NOT INCLUDED IN YOUR 837. PLEASE RESUBMIT YOUR CLAIM WIT *** NO DATA TO REPORT *** DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. AMTNC INELIGIBLE TO RECEIVE SE RUICES IN IPPS. DUPLICATE OF CLAIM-SYSTEM DUPLICATE OF CLAIM-SYSTEM THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN | 0 | 9 | 1036 | 1027 |
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| 3404944 | EASTPOINTE HUMA | 8534 | 85 | SERVICE FACILITY LOCATION IS N OT A VALID IPRS ATTENDING | | | | |
| | N SERVICES | | | PROVIDER. PLEASE VERIFY THE F | | | | |
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| | | 8537 | 67 | PROCEDURE IS NOT PAYABLE FOR Y | 2 | 232 | 1434 | 1202 |
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| 3404946 | | | | ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | | |
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| 3404946 | FOOTHILLS AREAM ENTAL HEALT | | | ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | | |
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| | | | | | | | | |
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